STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165323	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Correctionville Specialty Care	1116 East Highway 20 Correctionville, IA 51016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, resident and resident family interviews, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 4 out of 4 residents (Resident #3, #4, #6 & #8) reviewed from abuse. The facility reported a census of 35 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of depression, anxiety disorder and heart failure. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the facility provided Incident Report dated 4/10/26 at 1:00 p.m., revealed Certified Nursing Assistant (CNA) reported that while giving the resident a bath the resident stated, I was eating in the living room but today I moved back to the dining room. She was asked why by the CNA. The resident responded I am afraid male resident is going to grope me. CNA verified the male resident. Resident continued to state last night male resident tried to put his hand up my shirt. CNA asked the resident if she told the male to stop. The resident stated yes, I said stop people are going to see, we are going to get into trouble. The resident stated, you are not going to like what I have to say. Male resident put his hand up my shirt twice. I told him no and he kept doing it. She explained what the male looked like, then stated that the resident did stop when she told him no. The resident denied wanting to call the police. The resident stated this happened at dinner in the dining room. Review of the Progress Notes revealed late entry dated 4/10/26 at 1:38 p.m., with a created date of 4/14/26 at 8:00 a.m., entered by the Administrator revealed resident reported to CNA that a male resident tried to touch her breast while eating supper. Resident was asked by the CNA if she had told the male resident to stop. Resident stated that yes I told him to stop, people are going to see and we're going to get into trouble. Interview on 5/4/26 at 10:25 a.m., with Resident #4 revealed has only had one incident where another resident has touched her breast. She explained she could not remember his name but they were sitting in the other dining room area and he took his hand and went under her t-shirt and touched the outside of her left breast area. She told him no and that she didn't want him to do that. She told him that everyone was looking and he said he didn't give a damn if everyone wanted to look. She stated she did tell the lady that gave her her bath. She explained that she does not feel unsafe in the facility and she just wants him to stay away from her and doesn't want him around her. She stated that she has had no further concerns with him after this one incident. Interview on 5/5/26 at 1:31 p.m., with Resident #5 revealed he was aware of the situation he was being asked about. He stated that he was sitting next to Resident #4 at the table and he doesn't (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the night and she went back to her room and closed the door. Review of written statement by Staff B, Certified Nursing Assistant (CNA) dated 3/25/26 revealed the following, On March 24, 2026 around 8:30 p.m., Resident #6 came up to the nurses station where Staff C CNA and I were sitting and charting. Staff D, Licensed Practical Nurse (LPN) was at her medication cart. I had seen Resident #6 when I looked up and waved and she had an upset expression. She then proceeded to ask us all who that old guy was that came into her room. We asked what had happened and she stated that when he had came into her room, she was sleeping naked and woke up to him trying to kiss her. She also stated that he asked her to have sex with him. Staff C asked her if she would feel more comfortable sleeping in a different room, she was not interested. Staff D told her we could keep an eye out if she wanted to stay in her room. Later on my shift around 3:00 a.m., I went to go into her room to refresh her water pitcher, I could not get the door open. She had barricaded the door to the point where I couldn't see in or move the door open. Signed and dated 3/25/26 by Staff B. Interview on 5/4/26 at 12:28 p.m., with Staff B, CNA revealed she was sitting at the nurses station and it was around 8:00 p.m., and stated that another staff and the nurse was there when Resident #6 came to the desk. She was coming down the hallway and she looked disgruntled which was unusual for her. She usually goes to bed early and it was unusual to see her up after she had gone to bed. She told us that Resident #7 came into her room and she didn't have any clothing on and she was sleeping under her covers and he tried to kiss her and proceeded to ask her to have intercourse with him. Resident #6 stated she told him she wanted to punch him in the face and he is an old man and no way. She explained he was standing so she was not able to pull her call light and she finally got him out of her room. They offered to move her room for the night and she denied as she wanted to stay in her room with her stuff. She stated that later during her shift that night she attempted to enter her room and she was unable to get into her room. She had barricaded the door as no one was able to enter her room after the incident occurred. Review of written statement by Staff C, CNA on March 24, 2026 Resident #6 came up the hallway to the nurse's station where Staff B and Staff D and I were sitting by the nurse's station. Staff D was standing at her medication cart. Staff B and I were sitting behind the nurses station. Resident #6 stood beside Staff D and asked who that old guy was. This happened around 8:30 p.m., About 30 minutes prior to Resident #6 coming up to the station, I had noticed Resident #7 wandering the hallway, then go into Resident #6's room. Resident #6 is an independent resident who sleeps with no clothes on at night because normally only staff that are working go in there. She is always covered up with multiple blankets. When Resident #6 came up to the nurses station. She was asking about who that old guy was. I asked her if she was talking about Resident #7 and told her she looked upset. She stated she was upset because Resident #7 came into her room while she was sleeping and kissed her. She then stated she was naked. I asked her if that's all that happened. She said no that he asked her to have sex with him. I asked her if she would like to stay in a different room for the night, she declined. Staff D then told her she could go back to her room, and that we would make sure Resident #7 did not go in there. Resident #7 returned to her room. I informed the other CNA's on duty, then returned to my work. Signed by Staff C. Interview on 5/4/26 at 12:40 p.m., with Staff C, CNA revealed that she was at the nurses station and Resident #6 had been sleeping in her room. She sleeps naked as she is independent and the staff usually just checks on her. She was coming down the hallway and it was weird to see her out of her room at that time of the night. Resident #6 came up to her and asked who is that old guy? She stated Resident #7 had walked down the hallway and came into her room and she was under her blankets and he tried to kiss her and have sex with her. Resident #6 was noted to be very uncomfortable. Staff (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	offered a different room for the night and resident declined as she wanted to stay in her own room Interview on 5/5/26 at 12:52 p.m., with Staff D, LPN revealed she was at the nurses station when Resident #6 came to the nurses station. Resident #6 explained Resident #7 came into her room and attempted to kiss her and she told him no and asked what was wrong with him as he came into her room and tried to kiss her. Resident #6 said he was messing with the front of his pants but never said if he had exposed himself but did say he wanted to have sex. Staff D explained they offered her another room but she declined as she wanted to stay in her room with her stuff. 3. The MDS assessment dated [DATE] for Resident #8 documented diagnoses of difficulty walking, muscle weakness and respiratory failure. The MDS showed the BIMS score of 11 indicating moderate cognitive impairment. Review of the facility provided Incident Report dated 4/18/26 at 8:00 a.m., revealed the resident came up to the nurses station asking who she had to talk to report something. Asked what happened multiple times at different times and got the same story, skin assessment was performed. The resident stated that she was hit last night and staff made her use a bedpan. Wasn't able to name staff and states that we all look alike with height and dark hair. Once they pulled the bed pan out from under her, the staff raised the bed pan unsure of its exact posture and struck the resident in hip and other thigh with the bedpan. Resident stated there was yelling between self and staff. The resident wasn't able to give a time but did state she was in a nightgown and hours after eating meals. The resident was asked how many people were in the room, stated 1 she was asked and she reported the abuse last night she stated no I just went back to sleep. Review of Resident #8's Progress Notes revealed the following: On 4/18/26 at 10:58 a.m., resident came up to the nurses station requesting to report abuse stating that the overnight staff had struck her with a bed pan after they pulled it out from underneath her striking her in the hip and thigh. Skin assessment was performed and found two 4 centimeter (cm) superficial scratches with no drainage on the lower back. The resident denies any pain related to those. The resident was not able to give the name or description of the staff stating we all look alike with dark hair and size. The resident stated there was yelling in between self and staff. A neighboring resident was asked if she heard anything. She also heard yelling around 1:00 a.m., but wasn't able to directly say what she heard. The family was called and updated on issues. Son did come to the facility at bedside with the resident. Managers updated. On 4/18/26 at 11:23 a.m., Resident called daughter and had complaints of pain in the hip. Nurse went down to resident room asking about pain. Denies any pain at this time, no bruising or edema noted. Pain medication was offered. Non-pharmacological comforts were offered and resident denied. On 4/18/26 at 12:09 a.m., skin issues- new skin issue on lower middle back noted to be a new wound acquired in house. Abrasion. Length- 0.96 cm, Width- 0.86 cm. Interview on 5/6/26 at 1:41 p.m., with Resident #8 revealed that she didn't want anyone to get into trouble. She explained that she didn't know the staff's name but there was only one incident where they hurt her with the bed pan. She stated it was at nighttime and the staff member kept pushing the bedpan and Resident #8 didn't want to use the bed pan. Resident #8 stated the staff member told her she needed to use the bed pan and the resident wanted to use the toilet. The resident said when the staff put the bedpan under her it hurt. Resident #8 said several times, she hurt me with the bedpan. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it together. When we reached her room, Staff L asked her what she needed, Resident #3 replied that she needed to use the restroom. Staff L then told her she needed to get up on the side of the bed herself. Resident #3 responded with, I need help. I can't do it. Staff L told her she was not going to help her and that she was not going to break her back, helping her. She did end up helping her, but she was not nice and while she was having this conversation with Resident #3, her voice was raised. The facility's policy titled Abuse, Neglect, Exploitation or Misappropriation: Reporting and Investigating, last revised April 2021, indicated that allegations involving abuse or resulting in serious bodily injury must be reported within two hours to local, state, and federal agencies. The policy instructs that if abuse, neglect, exploitation, misappropriation of property, or an injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and other officials according to regulations. The Administrator or the individual making the allegation is responsible for reporting the suspicion immediately. In an interview on 5/6/26 at 2:13 PM, the Administrator stated she had contacted the relevant outside agencies to establish an abuse reporting process. She also evaluated internal protocols to ensure the facility receives and processes reports of abuse allegations in a timely manner, consistent with regulatory requirements. The Administrator further reported that recent staff meetings yielded additional information regarding Staff L. Consequently, she provided supplemental education to all staff regarding abuse reporting, emphasizing that she must be notified immediately of any concerns, including via her personal cell phone.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Correctionville Specialty Care	1116 East Highway 20 Correctionville, IA 51016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 2 of 4 residents reviewed for abuse (Resident #3 & #6). The facility reported a census of 35 residents. Findings include:1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented diagnoses of hypertension, muscle weakness and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Interview on 5/5/26 at 10:44 a.m., with Resident #6 revealed she was sleeping in bed unclothed when that old man (Resident #7) came into her room. Resident #6 revealed he was sitting next to her bed and she asked him what he was doing and he leaned over and kissed her around her mouth area. Resident #6 again asked him what he was doing and he said come on and he kissed her again on the cheek area. Resident #6 told Resident #7 no and to leave and get out of her room. She explained he finally left the room and she got up and got dressed and walked all the way down to the desk where there was some young staff working. Resident #6 told the staff Resident #7 kissed her. She explained the staff thought it was funny and she told them it was not funny she did not want that old man kissing her. The staff told her they would watch him and make sure he didn't bother her the rest of the night and she went back to her room and closed the door. Review of written stated by Staff B, Certified Nursing Assistant (CNA) dated 3/25/26 revealed the following, On March 24, 2026 around 8:30 p.m., Resident #6 came up to the nurses station where Staff C. CNA and I were sitting and charting. Staff D, Licensed Practical Nurse (LPN) was at her medication cart. I had seen Resident #6 when I looked up and waved and she had an upset expression. She then proceeded to ask us all who that old guy was that came into her room. We asked what had happened and she stated that when he had came into her room, she was sleeping naked and woke up to him trying to kiss her. She also stated that he asked her to have sex with him. Staff C asked her if she would feel more comfortable sleeping in a different room, she was not interested. Staff D told her we could keep an eye out if she wanted to stay in her room. Later on my shift around 3:00 a.m., I went to go into her room to refresh her water pitcher, I could not get the door open. She had barricaded the door to the point where I couldn't see in or move the door open. Signed and dated 3/25/26 by Staff B. Review of written statement by Staff C, CNA on March 24, 2026 Resident #6 came up the hallway to the nurse's station where Staff B and Staff D and I were sitting by the nurse's station. Staff D was standing at her medication cart. Staff B and I were sitting behind the nurses station. Resident #6 stood beside Staff D and asked who that old guy was. This happened around 8:30 p.m., About 30 minutes prior to Resident #6 coming up to the station, I had noticed Resident #7 wandering the hallway, then go into Resident #6's room. Resident #6 is an independent resident who sleeps with no clothes on at night because normally only staff that are working go in there. She is always covered up with multiple blankets. When Resident #6 came up to the nurses station. She was asking about who that old guy was. I asked her if she was talking about Resident #7 and told her she looked upset. She stated she was upset because Resident #7 came into her room while she was sleeping and kissed her. She then stated she was naked. I asked her if that's all that happened. She said no that he asked her to have sex with him. I asked her if she would like to stay in a different room for the night, she declined. Staff D then told her she could go back to her room, and that we would make sure Resident #7 did not go in there. Resident #7 returned to her room. I informed the other CNA's on duty, then (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned to my work. Signed by Staff C. Review of Resident #6's Progress Notes dated 3/24/26 at 12:53 p.m., entered on 3/30/26 at 12:54 p.m., by Staff F, Registered Nurse (RN) revealed mother was notified of physical aggression received by another resident. Explained interventions provided to resident and residents current status. Mother verbalized understanding, she has no further complaints or concerns as long as Resident #6 is okay. Review of facility reported incident revealed submission date of 3/25/26 at 12:22 p.m Interview on 5/5/26 at 9:42 a.m., with Staff F revealed she talked to the Administrator and Regional Nurse Consultant on the phone as they were out of the facility and that she did the Incident Report as the nurse that was working that evening did not do it as she did not think it was an incident and that's why they didn't call anyone. She explained she educated the staff they needed to call especially with an incident like this. Interview on 5/6/26 at 3:15 p.m., with the Administrator revealed if there is an allegation of abuse reported to staff that is to be reported within 2 hours of the allegation. Staff should have called right away about the incident. 2. The MDS assessment dated [DATE] for Resident #3 showed reentry to the facility from home occurred on 4/13/2026. The Medical Diagnosis record for Resident #3 showed a diagnosis of muscle wasting, abnormal posture, and morbid obesity. Review of the email dated 4/28/26 at 4:09 PM showed that an outside care provider notified the facility regarding Resident #3's report of mistreatment by an overnight nurse. The email stated the nurse opened Resident #3's door and hollered, come on lets go. The nurse aggressively pulled Resident #3's legs to move her out of bed. The resident indicated she did not report this incident to leadership. The untitled documented interview the Administrator conducted with the nurse accused of mistreating Resident #3 was dated and timed for 4/28/26 at 6:10 PM. Review of facility intake information the facility submitted a self report on 4/28/2926 at 8:15 PM. The facility failed to report an allegation of abuse to DIAL within 2 hours of an allegation of abuse. The Abuse, Neglect, Exploitation or Misapproiation- Reporting and Investigating policy last revised April 2021 indicated allegations involving abuse or result in serious bodily injury needed to be reported within two hours to local, state and federal agencies as required by current regulations. During an interview on 5/6/26 at 2:13 PM, the Administrator stated she contacted the receiving agency to establish an abuse reporting process. She also evaluated other agencies for necessary process changes to ensure the facility receives reports of abuse allegations involving residents in a timely manner to meet regulation requirements.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview the facility failed to revise and update care plans to include appropriate interventions for residents to prevent repeated falls and resident to resident altercations for 2 out of 3 residents reviewed (Resident #1 and #4). The facility reported a census of 35 residents. Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of Parkinson's Disease, symptoms of and signs with cognitive functions and awareness, and history of falling. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. During an interview on 5/5/26 at 11:16 AM, Staff E, Registered Nurse (RN) recalled a fall involving Resident #1 in April 2026. The RN remembered the resident attempted to walk from the bathroom to his wheelchair when he fell by the wheelchair. When asked about documenting the fall details, the nurse reported she hoped she performed them and thought she documented the specifics. Regarding protocol for an unwitnessed fall, the RN reported risk management information, a head-to-toe assessment, an intervention, neurological assessments and documentation are required per facility policy. Review of the Care Plan for Resident #1 showed no documentation of interventions for a fall that occurred in April 2026. During an interview on 5/6/26 at 2:13 PM, the Administrator stated she had no knowledge of Resident #1 falling in April. The Administrator stated the nurse failed to determine immediate interventions. The Administrator explained for the care plan process the nurse determined and documented immediate interventions based on the fall. Leadership reviews the fall, determines if the intervention was appropriate, and then adds the intervention to the care plan. The Administrator acknowledged that because the fall was not identified, no interventions were determined to prevent future falls. 2. The MDS assessment dated [DATE] for Resident #4 documented diagnoses of depression, anxiety disorder and heart failure. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the Progress Notes revealed late entry dated 4/10/26 at 1:38 p.m., with a created date of 4/14/26 at 8:00 a.m., entered by the Administrator revealed resident reported to CNA that a male resident tried to touch her breast while eating supper. Resident was asked by the CNA if she had told the male resident to stop. Resident stated that yes I told him to stop people are going to see and we're going to get into trouble Review of the facility provided Incident Report dated 4/10/26 at 1:00 p.m., revealed immediate action taken included resident asked the staff if they could just have boundaries with male resident, she would feel comfortable. She stated that she sees him in common areas and stated that she would tell him to stay away from her or ask someone to help her. The Care Plan with a revision date of 4/14/26 lacked interventions following the incident on 4/9/26. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided policy titled Care Plans, Comprehensive Person-Centered with a revised date of December 2016 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Interview on 5/6/26 at 3:15 p.m., with the Administrator revealed the care plans should be updated with interventions as they are implemented for the residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and resident and staff interviews, the facility failed to ensure that a resident who experienced a fall received the necessary care and services to maintain their highest practicable physical well-being. For 1 of 3 residents reviewed (Resident #1), nursing staff failed to conduct a thorough assessment, implement immediate interventions, perform required neurological checks, or notify the resident's physician and family following an unwitnessed fall for 1 of 3 residents reviewed (Resident #1).Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of Parkinson's Disease, symptoms of and signs with cognitive functions and awareness, and history of falling. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. During the interview on 5/4/26 at 3:40 PM, Staff A, Certified Nursing Assistant (CNA) stated she found Resident #1 on the floor near the wheelchair upon entering the room. Resident #1 reported losing his footing and falling while walking from the bathroom to his wheelchair. Staff A reported the incident occurred between 7:00 and 7:15 AM on the second or third Sunday of April 2025, before Resident #1 ate breakfast and attended church. Staff A reported the fall to Staff E (RN). Staff E reported Staff A entered the room, asked Resident #1 about a head injury, and assisted the resident from the floor. Resident #1 denied injuries. During an interview on 5/5/26 at 11:16 AM, Staff E, Registered Nurse (RN) recalled a fall involving Resident #1 in April 2026. The RN remembered the resident attempted to walk from the bathroom to his wheelchair when he fell by the wheelchair. The resident reported his legs gave out and denied hitting his head or sustaining other injuries. When asked if she completed and documented an assessment, the nurse replied, I don't remember but I should have. When asked if the nurse completed and documented a neurological assessment, the nurse stated, I would hope so. When asked about documenting the fall details, the nurse reported she hoped she performed them and thought she documented the specifics. Regarding protocol for an unwitnessed fall, the RN reported risk management information, a head-to-toe assessment, an intervention, neurological assessments and documentation are required per facility policy. The RN failed to recall who found the resident, though she remembered the incident occurred on a Sunday morning before church. Review of the Care Plan for Resident #1 showed no documentation of interventions for a fall that occurred in April 2026. Review of the Progress Notes for Resident #1 showed no documentation for a fall that occurred in April 2026. Review of the Clinical Assessment for Resident #1 revealed no documentation of an assessment, including vital signs, head-to-toe evaluation, or neurological assessment, for a fall that occurred in April 2026. The facility's April 2026 Incident Reports for Resident #1 lacked any record of a fall. As a result, the documentation omitted an immediate assessment, neurological assessment, cause identification, and root cause analysis. The Resident Examination and Assessment policy revised 2014 instructed staff how to complete and document an assessment. The policy failed to identify what and specific assessments are to be completed after a fall. The Accidents and Incidents policy revised July 2017 required staff to investigate and report all resident accidents and incidents to the Administrator. The policy also mandated staff to conduct and document the resident's condition and vital signs, and notify the physician and family. The Fall and Fall Risk policy revised September 2017 indicated that for an individual who has fallen, the staff and practitioners will begin to try to identify possible causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse medication consequence, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. After more than one fall, the physician should at least review the resident/patient's neurological status, medical conditions, and current medications that may be associated with dizziness or falling. Many categories of medications, and especially combinations of medications in (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	several of those categories, increase the risk of falling. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. During an interview on 5/6/26 at 2:13 PM, the Administrator denied knowledge of Resident #1 falling in April. She determined the nurse on duty as Staff E and reported following up with her regarding incomplete tasks and documentation. She emphasized the requirement for staff to follow facility policy for falls. The Administrator stated the nurse failed to complete required assessments, neurological checks, cause identification, and immediate interventions. Additionally, the nurse failed to notify the physician, family, or administration.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, family and staff interviews, the facility failed to provide appropriate supervision to ensure each resident's individual safety while using the commode for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 35 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of dementia, anxiety disorder, and repeated falls. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. The Care Plan for Resident #2 indicated a risk for falls due to increased restlessness and anxiety. Resident #2 was documented as non-ambulatory and required assistance with a stand lift, though the resident expressed a preference for using the commode. During an interview on 5/5/26 at 11:05 AM, Resident #2's roommate recalled an incident on the night before Easter when Resident #2 waited on the commode around bedtime. The roommate noted that Resident #2 did not mention a missing call light. Staff informed Resident #2 they would allow her time and set an alarm. The roommate eventually pulled her own call light and started down the hall to find staff, but saw them approaching. The roommate estimated that staff returned after 30-45 minutes total, though she did not know exactly when Resident #2 finished and possibly signaled for help. The roommate confirmed she did not watch the clock during this time. During an interview on 5/4/25 at 11:33 AM, Resident #2 stated, I was on the commode for about an hour. Resident #2 reported this happened once, although she failed to remember the date. When asked if she held the call light, Resident #2 stated, I can't remember if I had the call light. When asked how she knew an hour passed without a clock, Resident #2 stated, It felt like an hour or two. I don't have a clock. When asked for the duration of her bowel movement, she reported she did not know and could not recall if she had a bowel movement at that time. When asked if she experienced skin issues or soreness from waiting on the commode, Resident #2 responded, no. When asked if staff acted rough or disrespectful, Resident #2 stated, no. When asked if the staff acted nice, Resident #2 stated, yes. During an interview on 5/4/26 at 3:40 PM, Staff A, a Certified Nursing Assistant, stated that she forgot Resident #2 on the toilet one night. Staff A and another colleague working in that hall set a timer to prompt them to assist Resident #2 off the commode. When the timer sounded, Staff A was in another resident's room and forgot about the alert. Staff A could not recall the exact time of the incident but estimated it was around 8:30 PM. Staff A stated that the night shift found the resident still on the commode around 10:00 PM. When asked if Resident #2 had a call light, Staff A replied no, because the cord was too short to reach the commode. When asked if the short cord prevented Resident #2 from using the call light while on the commode, Staff A stated that it sometimes did, depending on the room arrangement and the location of the commode. In an interview on 5/5/26 at 12:47 PM, Staff D, a Licensed Practical Nurse (LPN), acknowledged that Resident #2 remained on the commode for an extended period. Staff D explained that her staff informed her that the resident had been on the commode since the previous shift. She noted that staff typically placed the resident on the commode around 8:00 PM for 10 to 15 minutes. When asked if Resident #2 could reach the call light, Staff D stated, no. She explained that the roommate eventually activated her own call light to alert staff. Staff D admitted she previously instructed the staff to keep the call light within reach, noting it was not the first time the resident could not access it. She recalled finding the call light behind the bed or hearing from the resident directly that it was unreachable. Staff D confirmed she did not check on or assess Resident #2 after receiving the report because the staff claimed the resident was fine. She also admitted she did not complete risk management documentation or an incident report. Staff D noted that the resident mentioned the incident the following night but did not report any soreness. Staff D stated she was unaware of any skin issues resulting from the incident. She estimated that staff found the resident around 10:30 PM. During an interview on 5/5/26 at 12:31 PM, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff O stated, I was working when Staff A put Resident #2 on the commode at about 8:30 PM. During the report, Staff A, CNA, told staff that everyone in her hall was good. After the report the light came on; I came around the corner and saw the stand lift with the brakes on. Resident #2 said she was sitting there for a while. We got her off and cleaned her; she had a very deep indentation. By the time she was wet again about 2:00 AM, the indentation was gone. Resident #2 said that her butt hurt and that she couldn't feel her feet. We used the stand lift; she was okay. I didn't speak with Staff A about it. Staff A worked the day shift the next day, but Staff D, LPN, talked to her about the resident not having a call light. That is a problem because they set timers and use alarms on their watches. They tuck Resident #2's call light behind the bed. They don't want to give her the call light because then she calls them back in 15 to 20 minutes. The Accidents and Incidents policy, last revised in July 2017, requires staff to investigate and report all resident accidents or incidents to the Administrator and the immediate supervisor or department director. Staff must promptly initiate a documented investigation, assess the resident, monitor vital signs, and implement corrective actions. The policy also instructed staff to complete an incident form and submit the form to the Director of Nursing Services. During an interview on 5/6/26 at 2:13 PM, the Administrator stated that she was unaware of the incident involving Resident #2. The Administrator explained that staff must always provide the resident with a call light, regardless of how frequently she requests assistance. She also reported that staff use a timer in addition to the call light to prevent Resident #2 from sitting for too long, which allows the resident extra time to empty her bladder. The Administrator noted she was unaware that the call light cord was too short to reach the commode and stated that maintenance would fix the length immediately. Furthermore, she reported she was unaware that staff were tucking the call light away to prevent its use and committed to addressing this with staff immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide and maintain accurate resident records to reflect incidents that occurred in the facility for 2 of 3 residents (Residents #1 and #6). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of Parkinson's Disease, symptoms of and signs with cognitive functions and awareness, and history of falling. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. During the interview on 5/4/26 at 3:40 PM, Staff A, Certified Nursing Assistant (CNA) stated she found Resident #1 on the floor near the wheelchair upon entering the room. Resident #1 reported losing his footing and falling while walking from the bathroom to his wheelchair. Staff A reported the incident occurred between 7:00 and 7:15 AM on the second or third Sunday of April 2025, before Resident #1 ate breakfast and attended church. Staff A reported the fall to Staff E, RN. Staff E reported Staff A entered the room, asked Resident #1 about a head injury, and assisted the resident from the floor. Resident #1 denied injuries. During an interview on 5/5/26 at 11:16 AM, Staff E, RN recalled a fall involving Resident #1 in early April. The RN remembered the resident attempted to walk from the bathroom to his wheelchair when he fell by the wheelchair. The resident reported his legs gave out and denied hitting his head or sustaining other injuries. When asked if she completed and documented an assessment, the nurse replied, I don't remember but I should have. When asked if the nurse completed and documented a neurological assessment, the nurse stated, I would hope so. When asked about documenting the fall details, the nurse reported she hoped she performed them and thought she documented the specifics. Regarding protocol for an unwitnessed fall, the RN reported risk management information, a head-to-toe assessment, an intervention, neurological assessments and documentation are required per facility policy. The RN failed to recall who found the resident, though she remembered the incident occurred on a Sunday morning before church. Review of the Care Plan for Resident #1 showed no documentation of interventions for a fall that occurred in April 2026. Review of the Progress Notes for Resident #1 showed no documentation for a fall that occurred in April 2026. Review of the Clinical Assessment for Resident #1 showed no documentation for a fall that occurred in April 2026. Review of the facility's April 2026 incident reports for Resident #1 showed no report of a fall in April 2026. The Documentation policy dated January 2015 required that all documentation (patient records, financial records, etc.) be accurate, timely and prepared in a professional manner. No employee should ever knowingly falsify any document prepared for, or submitted to, any government agency or private payor source for any purpose. All individuals who contribute information to a medical record must (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide accurate and complete information. During an interview on 5/6/26 at 2:13 PM, the Administrator stated she had no knowledge of Resident #1 falling in April. She determined the nurse to be Staff E, RN and recently followed up with Staff A for not completing tasks and documentation. She emphasized that staff must follow facility policy regarding documentation. 2. The MDS assessment dated [DATE] for Resident #6 documented diagnoses of hypertension, muscle weakness and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Interview on 5/5/26 at 10:44 a.m., with Resident #6 revealed she was sleeping in bed unclothed when that old man (Resident #7) came into her room. Resident #6 revealed he was sitting next to her bed and she asked him what he was doing and he leaned over and kissed her around her mouth area. Resident #6 again asked him what he was doing and he said come on and he kissed her again on the cheek area. Resident #6 told Resident #7 no and to leave and get out of her room. She explained he finally left the room and she got up and got dressed and walked all the way down to the desk where there was some young staff working. Resident #6 told the staff Resident #7 kissed her. She explained the staff thought it was funny and she told them it was not funny she did not want that old man kissing her. The staff told her they would watch him and make sure he didn't bother her the rest of the night and she went back to her room and closed the door. Review of written stated by Staff B, Certified Nursing Assistant (CNA) dated 3/25/26 revealed the following, On March 24, 2026 around 8:30 p.m., Resident #6 came up to the nurses station where Staff C. CNA and I were sitting and charting. Staff D, Licensed Practical Nurse (LPN) was at her medication cart. I had seen Resident #6 when I looked up and waved and she had an upset expression. She then proceeded to ask us all who that old guy was that came into her room. We asked what had happened and she stated that when he had came into her room, she was sleeping naked and woke up to him trying to kiss her. She also stated that he asked her to have sex with him. Staff C asked her if she would feel more comfortable sleeping in a different room, she was not interested. Staff D told her we could keep an eye out if she wanted to stay in her room. Later on my shift around 3:00 a.m., I went to go into her room to refresh her water pitcher, I could not get the door open. She had barricaded the door to the point where I couldn't see in or move the door open. Signed and dated 3/25/26 by Staff B. Review of written statement by Staff C, CNA on March 24, 2026 Resident #6 came up the hallway to the nurse's station where Staff B and Staff D and I were sitting by the nurse's station. Staff D was standing at her medication cart. Staff B and I were sitting behind the nurses station. Resident #6 stood beside Staff D and asked who that old guy was. This happened around 8:30 p.m., About 30 minutes prior to Resident #6 coming up to the station, I had noticed Resident #7 wandering the hallway, then go into Resident #6's room. Resident #6 is an independent resident who sleeps with no clothes on at night because normally only staff that are working go in there. She is always covered up with multiple blankets. When Resident #6 came up to the nurses station. She was asking about who that old guy was. I asked her if she was talking about Resident #7 and told her she looked upset. She stated she was upset because Resident #7 came into her room while she was sleeping and kissed her. She then stated she was naked. I asked her if that's all that happened. She said no that he asked her to have sex with him. I asked her if she would like to stay in a different room for the night, she declined. Staff D then told her she could go back to her room, and that we would make sure Resident #7 did not go in there. Resident #7 returned to her room. I informed the other CNA's on duty, then returned to my work. Signed by Staff C. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165323	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Correctionville Specialty Care	1116 East Highway 20 Correctionville, IA 51016

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility reported incident revealed submission date of 3/25/26 at 12:22 p.m Review of Resident #6's Progress Notes dated 3/24/26 at 12:53 p.m., entered on 3/30/26 at 12:54 p.m., by Staff F, Registered Nurse (RN) revealed mother was notified of physical aggression received by another resident. Explained interventions provided to resident and residents current status. Mother verbalized understanding, she has no further complaints or concerns as long as Resident #6 is okay. Review of facility provided policy titled Documentation Policy dated January 2015 revealed the policy requires that all documentation be accurate, timely and prepared in a professional manner. If you are using the late entry to document an omission, make sure you validate the source of additional information as much as possible. Interview on 5/6/26 at 3:15 p.m., with the Administrator revealed staff should be accurately documenting the incidents when they happen. The nurse that was working at the time should have documented the incident that night.